EXHIBIT D

Copy

NEUROLOGISTS

RUSSELL E. MOHNEY, M.D.
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AZZAM S. KANAAN, M.D.
PHILLIP M. GREEN, M.D.
ILYDIO POLACHINI, M.D.
THOMAS C. DUNNE, M.D.
RAJESH D. DAGLI, M.D.
MOHAMMED J. ZAFAR, M.D.
IGOR G. KAPS, M.D.

NEURORADIOLOGIST

JEFFREY C. DIPAOLO, M.D.

KALAMAZOO NEUROLOGY, P.C.

Location to be Drawn_____ Date_____

Appointment if needed - Date_____ Time_____ am_____ pm

HEMATOLOGY

___CBC
___Differential
___Platelets
___Sed Rate
___PT
___PTT

CHEMISTRY

Profiles:
___Profile 12___Fasting___Random
___Profile 22___Fasting___Random
___Lipid Profile (12 hr fast)
___Liver Profile
___Electrolytes
___Blood Gas Studies (Drawn at hosp)

Individual Chemistries:
___BUN
___Creatinine
___Fasting Glucose (10-12 hr fast)
___Glucose, 2hr PP (requires diet)
___Glucose, 2hr PC
___Glucose Tolerance Test (by appt)
___3hr (requires diet)
___4hr
___5hr
___Potassium
___Sodium
X SGOT

Urine Testing:
___Urinalysis
___Culture if over 5 WBC
___Urine Culture (Clean catch)
___24hr Urine Collections (take home)
___Copper
___Heavy Metals
___Immunoelectrophoresis
___Protein Electrophoresis
___VMA

IMMUNOLOGY

___ANA
___B-12
___Folate
___Immunoelectrophoresis (inc SPE & Qnt Ig's)
___Protein Electrophoresis (SPE)
___Rheumatoid Factor (RF or RA)
___Schillings___w/o___w (by appt)
___Syphilis Serology (RPR or VDRL)

Thyroid Studies:
___T-4
___T-3/T-4
___TSH

ANTICONVULSANT LEVELS

___Dilantin (Phenytoin)
___Depakene (Valproic Acid)
___Mysoline (Mys, Pb)
___Phenobarbital
___Tegretol (Carbamazepine)

OTHER

SGPT

Patient Jean Prowse DOB 2/27/24 Doctor Green

Diagnosis_____ Insurance_____ Date 11/15/03

COPY

KALAMAZOO NEUROLOGY, P.C.
1717 Shaffer Rd., Box 329, Kalamazoo, MI 49001
(616) 381-7880

Call Nelson

NAME: JAN PHONE: DATE: 11/06/93

ADDRESS: 3908 Fir Avenue PT ACCT # 96798

Kalamazoo 49006 381-5669

HOME PHONE: 000 0000 D.O.B. 00/00/00 2/27/94

WORK PHONE: 000 0000 REFERRING DOCTOR:

PHYSICIAN'S ORDERS

___ EEG awake	BLOOD LEVELS	OTHER:
___ CT of brain	___ DILANTIN	
___ MRI	___ TEGRETOL	
___ EMG	___ DEPAKOTE	
___ X-RAY	___ PHENOBARBITAL	___ RECHECK:
___ EVOKE	T4	___ REFER TO: Carl with Help
___ MSLT/POLYSOMNOGRAM	P-12 / P-22	___ PHONE CALL:
___ LP	SED-A	
___ PT	T3, T4, TSH	___ ADMIT TO HOSP:
___ OT	R12, FOLATE	
	___ LIVER PROFILE	
	___ SGOT	

acetylcholine

YOU ARE SCHEDULED FOR THE FOLLOWING:

PROCEDURE/TEST	DATE, TIME & LOCATION	RESULTS
CT	11/12/93 12:00	Borgess
EEG	11/12/93 11:00	Borgess
HSG		

Neurological Diagnosis

Migraine

Neurologist

Repeat SGOT 2 in 2 weeks
SGPT 3

11/15/93 - repeat labs in 2 weeks Ben

14-11-23 · 16:40

Newport Imaging Center
360 San Miguel Drive
Suites 105 & 108
Newport Beach, CA 92660
(714) 731-8191
FAX (714) 721-1206

CONSULTATION REPORT

M. MORRIS, M.D.
1441 # 709

PATIENT NAME: PROWSE, JAN
PATIENT ID*: 04-60-26

REFERRING PHYSICIAN:

EXAMINATION: MRI OF BRAIN

DATE OF EXAMINATION: 03/08/93

CLINICAL HISTORY: Short term memory loss.

TECHNIQUE: Sagittal T1 and dual echo axial images were obtained of the brain.

FINDINGS: The gray and white matter demonstrate normal signal characteristics. The ventricles and basal cisterns are normal in size and configuration. No abnormal intra or extra-axial fluid collections or masses are seen. The vascular flow void pattern is normal. The paranasal sinuses are clear.

The contents of the posterior fossa is normal with midline fourth ventricle.

CONCLUSION:

1. **NORMAL STUDY.**

Thank you for referring this patient to our office.

H. C. JENSEN, M.D.

HCJ:rrs
T: 03/08/93

BRONSON

Center for LifeLong Health

Geriatric Assessment

DATE: September 1, 1992

NAME: Jan Prowse

REFERRAL AGENT: Gerald Prowse ~ Husband

PHYSICIAN: Dr. Fry

COPIES TO: Gerald Prowse and Linda Groenhof (daughter)

REASON FOR REFERRAL: To investigate short-term memory loss problems.

NURSING DIAGNOSIS:

1. **Alterations in thought processes** related to short-term memory deficits. Her family reports that she has become forgetful, there are periods of confusion and difficulty remembering over the past year. During the interview, there was difficulty for her to come to a conclusion or be decisive as there was a need for frequent verification of her thoughts and for cuing to complete the idea, as she had difficulty remembering even what her first husband's last name was. There is no history of unusual precipitating factors prior to the onset of the short-term memory deficit a year ago.

2. **Alterations in the cardiac vascular system** related to the blood pressure of 170/90 and 168/92 with a questionable left carotid bruit. She has a history of hyperlipoproteinemia.

3. **Potential for injury** related to the lack of awareness of limitations imposed by her memory deficits. She is still driving her automobile.

4. **Noncompliance with the prescribed low cholesterol diet** or follow up after her bleeding gastric ulcer. She states that she does not like to go to the doctor for any reason.

5. **Alterations in nutrition more than body requirements** as manifested by a weight gain of 10# this year. She states that she eats ice cream on a daily basis.

Bronson Center for LifeLong Health Bronson Crosstown Center
150 E. Crosstown Pkwy - Suite 112
Kalamazoo, Michigan 49001-2869
(616) 341-8585

TEAM RECOMMENDATIONS:

1. We recommend that Mrs. Prowse be evaluated by her primary physician to rule out patho-physiological causes that may manifest itself with alterations in thought processes. For example: thyroid function test, folic acid, B12, VRDL, Panel 22 and a CBC. We suggest a CT scan to rule-out cranial pathology.

2. We recommend that Mrs. Prowse have a yearly pap test and mammogram done for screening purposes.

3. We recommend that her blood pressure be monitored to rule out hypertension and to have the left carotid artery evaluated for questionable bruit.

4. We recommend that the low cholesterol diet be complied with and to reduce the added salt in her diet, and to reduce the total fat intake, for example; by modifying the amount ice cream ingested per week. Please refer to the sample diets provided on recommending low cholesterol, low fat intake, a recommended ulcer diet, and no added salt diet. Contact Bronson's Nutrition Services at 341-6363 for any questions or diet-related concerns.

5. We recommend that a multivitamin be taken every day along with the niacin, garlic, calcium and fish oil. Taking the Vitamin C and B6 complex, B12 and Vitamin E in addition is mega dosing over the amount that is recommended. The Multi-vitamin, which contains the recommended dose of Vitamin C, Vitamin B complex and Vitamin E. Over ingestion of these vitamins can irritate the gastric mucosa lining and further irritate the already ulcerated lining. It is important to take vitamins with food and a large glass of water to help prevent the irritation and indigestion possible when taken on an empty stomach.

6. We recommend memory exercises be performed on a daily basis, such as; verbally communicating with husband, friends, and family, and to continue to read and to discuss, to problem solve, and to calculate (balancing checkbook, making out grocery lists,) and rehearsing new information. It may also be helpful to keep a small note pad and write new information so she is able to have easy reference to that new knowledge.

7. It is recommend to maintain order and schedule routine (eg: get up at 8 a.m., eat at 8:30 a.m., etc.) in the daily habits, and that positive reinforcement be provided for tasks that are completed successfully. We strongly suggest that she limit driving herself, for example to the mall, as periods of

confusion are potentially dangerous, and may result in accidents and getting lost.

MEDICAL SOCIAL WORK ASSESSMENT:

BACKGROUND: Mrs. Prowse was born in Arkansas and raised in Detroit, Michigan. She graduated from high school, had 3 children, Sharon Byrd, who lives in California and has 2 children and 1 grandchild. A daughter, Linda Groenhof who lives in California, has 2 children, and a son, Herbert who died at the age of 20 during open heart surgery. Mrs. Prowse worked at the Lockshore Dairy Company as an accountant, she has worked at a local bank answering phones for 4 or 5 years and then worked at Gilmore's as a receptionist for 6 years and retired from that position 5 years ago. She was married to Fred Roosenberg for 20 years and then remarried Gerald Prowse in 1965. Mr. Prowse worked for the Fetzer Broadcasting Company and is now retired. He has a history of hypertension, gout, skin cancer, gastric ulcers, irregular heart, and hiatal hernia. Jan Prowse's mother is 86, she has had 2 strokes and a broken hip. Her father died at the age of 56 from pneumonia and COPD. Jan Prowse has a sister, Evelyn Cholette, who has a history of emphysema, a sister, Alma, who has esophageal cancer, a brother, Harvey Stacks and a sister, Patricia Carmac who had a stroke at the age of 42.

SUPPORT NETWORK: Mrs. Prowse is supported by her two daughters, Sharon and Linda, and by her husband Gerald Prowse. She speaks of many friends that she walks at the mall with 5 days a week.

SOCIAL ACTIVITIES: Mrs. Prowse enjoys watching movies, she keeps busy with housekeeping. She enjoys reading and does some yard work with her husband.

HOME ENVIRONMENT: She lives in the Westwood neighborhood, which she perceives as safe. She has no difficulty climbing stairs, or managing the household chores.

QUALITY OF LIFE: She describes her life as happy, content, and satisfying.

FINANCIAL RESOURCES: She has Medicare, Social Security, pension and AARP secondary insurance. Her husband manages the financial affairs. Mrs. Prowse has her own checkbook and helps to manage the finances.

PATIENT'S NEEDS AND EXPECTATIONS: The family and Mrs. Prowse have expressed concern over the short-term memory changes that have occurred over the past year. They would like some recommendations for memory improvement.

NURSING ASSESSMENT: This is a 68 year old white female, who looks younger than her stated age. She is alert, she is oriented to person, place and time, although was unsure of the exact date. She is comprehending and able to follow what is said. She communicates with a nervous laughter. The content is appropriate. She denies having memory problems. Her flow of thought appears insecure as she is unable to come to a conclusion or to be decisive as she is questioning the validity of her thought and will check with her family to see if it is correct. She is able to stay on one topic, she is able to finish an idea with some cuing from her family members. Her rate of speech is appropriate, her affect is congruent with the situation. Her interaction skills are appropriate, she relates well, she is not withdrawn or preoccupied, she does not appear hostile toward any family member or this practitioner. Her facial expression is alert, and happy, she is comfortably dressed, with no offensive odors. She appears in no acute distress, there are no gross involuntary movements or structural abnormalities.

MEDICATIONS:

Vitamin C 250 mg b.i.d.
Multi-vitamin q.d.
B complex q.d
Vitamin B6 q.d
Vitamin B12 q.d.
Niacin q.d.
Vitamin E 400 units q.d.
Garlic 1 mg q.d.
Calcium 2 tablets q.d.
Fish Oil q.d.

On occasion she will take a digestive aid.

DRUG SENSITIVITY: None known

SUBSTANCE ABUSE: Denies tobacco or alcohol abuse.

HEALTH MAINTENANCE/HEALTH PERCEPTION: For the past one year, the family has noted a decline in the short-term memory, with trouble remembering, confusion, and loosing things. She has a history of a bleeding gastric ulcer that was treated two years ago, and occasionally complains of upper gastric pain. She also had an appendectomy several years ago.

NUTRITION: She has gained approximately 10# this year, she states that her appetite is good, she has a positive taste and smell, that two weeks ago she had her cholesterol drawn and was prescribed a low cholesterol diet for hypolipoproteinemia. She denies being

complaint with this diet.

Breakfast:	Cereal, milk, orange juice, decaffeinated coffee
Lunch:	Sandwich, soda
Dinner:	Salad and a meat
Snacks:	Ice cream every day

She has two to three 6 oz. glasses of water during the day. Her husband states that she does not eat enough fresh fruits or vegetables.

ELIMINATION:

BOWEL: She has a brown, formed stool every day without complaints of pain or hemorrhoids. She uses a hot cup of water an hour before breakfast and occasionally prune juice for a laxative.

BLADDER: She denies urinary loss, or urgency, during the day she urinates 4 to 5 times. She denies nocturia.

SLEEP/REST: She retires at 11 p.m., she falls asleep within 5 minutes and she states that she sleeps throughout the night. She denies having nightmares or bad dreams. She awakes at 7 a.m. feeling well rested. She denies leg cramps during the night. She will take a half hour to hour nap every day after lunch with her husband.

ACTIVITY/EXERCISE: She drives her own automobile to the local mall and will walk four times around the mall which is approximately a mile without experiencing chest pain, shortness of breath, or pain in her extremities. She states that she has energy to walk for long distances without tiring.

SEXUALITY: She was on birth control pills for heavy periods until menopause. She denies having any difficulties post menopausal, she denies vaginal itching, discharge, or changes in her breasts. She states that she is satisfied with her sexuality. She had three vaginal deliveries and breastfed.

ROLE/RELATIONSHIP: She states that her relationships are strong and meaningful.

FUNCTIONAL STATUS: 1=Independent 2=Assistance 3=Dependent

Feeding	1
Dressing	1
Ambulating	1
Toileting	1
Bathing	1

Transferring	1
Grooming	1
Housework	1
Shopping	1
Driving	1

She uses no assistive aid.

SELF PERCEPTION/SELF CONCEPT: She perceives herself as being friendly, cheerful, and with a stable mood.

COGNITIVE/PERCEPTUAL:
MINI MENTAL STATE EXAM SCORE: 25 out of a possible 30. Scores 25 or above are considered normal. Mrs. Prowse had difficulty with the short-term recall of three common objects after 5 minutes. A SET Test for Senile Dementia was given with a score of 28. Scores 25 or greater are interpreted as not being associated with dementia. A Functional Dementia Scale was completed by her husband, Gerald Prowse, he indicates that she loses things and becomes confused a good part of the time, and that most of the time she is having trouble remembering and that she is unaware of the limitations imposed by her memory changes, and some of the time she has had mood changes where she gets upset and cries.
VISUAL IMPAIRMENT: Denies any visual impairment. She does not wear glasses.
HEARING IMPAIRMENT: Denies hearing impairment, there are no hearing aids.
PAIN: She denies any pain in her body.
PRIMARY LANGUAGE: English, she has a high school education.
COMMUNICATION: She reads as a hobby. Her communication is at an appropriate rate, with some difficulty coming to a conclusion as her flow of thoughts are blocked by having difficulty with her short term memory.

There does not appear to be any visual, auditory, or other hallucinations or illusion reference. Her behavior during the interview was cooperative, and she was attentive with good eye contact and was able to concentrate and grasp the circumstance or event.

COPING/STRESS: A Geriatric Depression Scale was offered and there were a few indicators that she felt her memory was starting to become a problem and that it may be a little more difficult for her to concentrate or to make decision and that her mind was not as clear as it used to be. Although she denied feeling helpless or hopeless, she felt that she was full of energy and that she did not get upset over little things and that she enjoys being with people and she thinks that it is wonderful to be alive.

VALUE/BELIEF: She is a member of the Seventh Day Adventist Church, but is not currently active in church activities.

PHYSICAL ASSESSMENT:
VITAL SIGNS: BP - 170/90 left arm sitting, 168/92 left arm standing without dizziness; PULSE - 86 and regular; RESPIRATIONS - 16 and shallow; HEIGHT - 5'6"; WEIGHT - 148#
EYES: Right eye 20/30 without glasses, left eye 20/25, color vision is intact. Her pupils are equal, round, react to light, her EOM's are intact, she has peripheral vision in all gazes. Her sclera is a yellowish-white color with vascular injection. Her conjunctiva is pale pink. There was a small amount of whitish drainage noted in the medial canthus of both eyes. There was no indication of cataracts.
HEAD: Normal cephalic, her facial features are symmetrical, her scalp is non-tender without lesions, her hair is thick evenly distributed, blond and oily.
EARS: Tympanic membranes were pearly gray with a cone of light, her external auditory canals were pink without lesions in both ears. She was able to hear whispered voice.
NOSE: Her mucosa was pale pink, without lesions or polyps. She complained of right maxillary sinus tenderness upon palpation. There was no drainage noted, her nostrils were patent.
MOUTH: The tongue was midline, mobile, dry with anterior fissures. The buccal mucosa was pale pink, dry, without lesions.
THROAT: Pharynx and tonsils were red without exudate, she had a positive gag and swallow, her uvula was midline.
NECK: Supple with full range of motion. Thyroid appeared slightly enlarged although non-tender. There was no lymphadenopathy.
CHEST: Clear to percussion and auscultation to the basis.
CARDIOVASCULAR: She had a normal S1 S2 and regular rate and rhythm without murmur or ectopy. Pulse is 2+ radial, 2+ femoral, 2+ posterior tibula, 2+ pedel, 2+ carotid, there was a questionable left carotid bruit upon auscultation with the bell of the stethoscope and her breath held.
BREASTS: She had fibrocystic changes with complaints of tenderness, there were no detectable masses or dimpling, there were no axillary or infraclavicular lymph nodes
ABDOMEN: Soft, hypoactive bowel sounds, non-tender, and old healed appendectomy scar on the right lower quadrant.
SKIN: Pale pink, warm, dry, and intact. There were superficial varicosities on the lower legs and ankles.
SPINE: There was full range of motion to lateral bending and forward flexion. There was a slight kyphosis of the thoracic spine.
EXTREMITIES: She has full range of motion in her shoulder, elbows, wrists, hips, knees, ankles. Her toenails were thick, her feet were warm without edema. On the hands bilaterally, the first and second fingers there were arthritic changes noted on the distal interphalangeal joints.

NEURO: There was a negative Romberg, her hand, arm, and leg strength were 90%, she had the ability to toe and heel walk. She had good sensation in all dermatomes, her deep tendon reflexes were 2+ brachial radialis, 2+ popliteal, and her plantar reflexes were down. There were no gross motor tremors or involuntary movements. Her gait is steady, with a normal tandem walk.

R. Terry Martin, M.D.

Christopher Rieser, MSW, ASCW

Jeanine Stewart-Zelnis, MSN, RN, CS

HOME PAGE

CRITERIA FOR THE DIAGNOSIS OF PROBABLE ALZHEIMERS DISEASE

(National Institute of Neurological and Communicative Diseases and Stroke and distributed by the Long Island Alzheimers Foundation, 516 869-9627)

1. Criteria for clinical diagnosis of probable Alzheimers disease include:

- Dementia established by clinical examination and documented by Mini Mental (Folstein, Folstein, McHugh, 1975) Blessed Dementia Scale (Blessed, Tomlinson, Roth, 1968), or some other similar examination and confirmed by a neuropsychological tests
- Deficits into more areas of cognition, progressive worsening of memory and other cognitive functions
- No disturbance of consciousness
- Onset between ages 40 in 90, most often after age 65
- Absence of systemic disorders or other brain diseases that in a themselves could account for progressive deficits in memory and cognition

2. Diagnosis of probable Alzheimers disease is supported by:

- Progressive deterioration of specific cognitive functions, such as a language (Aphasia), motor skills (apraxia) and perception (agnosia)
- Impaired activities of daily living and altered patterns of behavior
- Family history of similar disorders, particularly if confirmed neuropathologically
- Laboratory results of normal lumbar puncture as evaluated by standard techniques, normal pattern or nonspecific changes in EEG, such as increased slow-wave activity, and evidence of cerebral atrophy on CT with progression documented by serial observation

3. Other clinical features consistent with diagnosis of probable Alzheimers disease, after exclusion of causes of dementia other than Alzheimers disease, include:

- Plateaus in course of progression of illness
- Associated symptoms of depression; insomnia; incontinence; delusions; illusions; hallucinations; catastrophic verbal, emotional, or physical outburst; sexual disorders; and weight loss
- Other neurological and analyses in some patients, especially with more advanced disease and including motor signs, such as increased muscle tone, myoclonus, or gait disorder
- Seizures in advanced disease
- CT normal for age

4. Features that make diagnosis of probable Alzheimers disease uncertain or unlikely include:

- Sudden apoplectic onset
- Focal neurological findings such as hemiparesis, sensory loss, visual field defects, and uncoordination early in the course of the illness
- Seizures or gait disturbance at onset or very early in course of illness

5. Clinical diagnosis of possible Alzheimers disease:

- May be made on basis of dementia syndrome, in absence of other neurological, psychiatric, or

systemic disorders sufficient to cause dementia and in the presence of variations in onset, in presentation, or in clinical course
- May be made in presence of second systemic or brain disorder sufficient to produce dementia, which is not considered to be cause of dementia
- Should be used in research studies when single, gradually progressive severe cognitive deficit is identified in absence of other identifiable cause

6. Criteria for diagnosis of definite Alzheimers disease are:

- Clinical criteria for probably Alzheimers disease
- Histopathological evidence obtained from biopsy or at autopsy

7. Classification of Alzheimers disease for research purposes should specify features that may differentiate subtypes of the disorders such as:

- Familial occurrence
- Onset before age of 65
- Presence of Trisomy-21
- Coexistence of other relevant conditions, such as Parkinson's disease
-

Alzheimers (2000)

Mild Stage

- Memory loss becomes more noticeable
- Concentrating and paying attention becomes harder, leading to difficulties in understanding written material, doing calculations, or making job-related decisions
- Misplacing or losing valuable items
- Momentary disorientation in familiar surroundings
- Some changes in personality and judgment

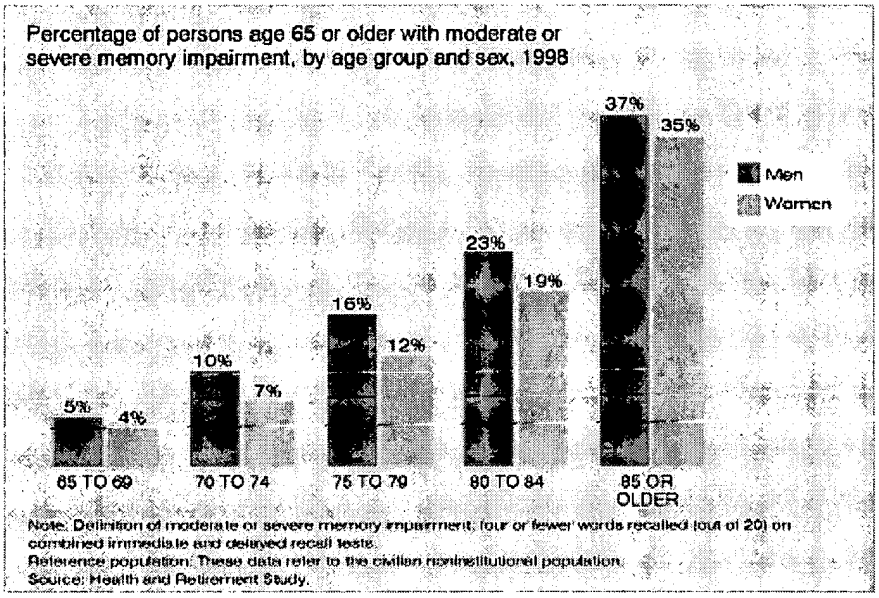
Moderate Stage

- Memory loss about recent events and some details of personal lives
- Inappropriate use of words
- Difficulty in performing such tasks as planning meals and dressing
- Increased disorientation
- Agitation, anxiety, suspiciousness
- Confusion between day and night
- Sleep disturbances
- Wandering off and not knowing how to return.
- Failure to recognize friends and relatives

Severe Stage

- Memory loss nearly complete
- Severe disorientation and confusion
- Speech declines to a few intelligible words
- Loss of physical functions like walking and sitting up

- Loss of bladder and bowel control
- Loss of appetite
- Total dependence on caregiver
-



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- BACK TO HOME
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